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Background and Purpose

The purpose of this "How To" Guide is to provide additional guidance on enrollment issues that are discussed in the State Guide to Integrated Medicare & Medicaid Models. This Guide applies to Special Needs Plans (SNP) in which a Medicare Advantage (MA) Organization contracts with both CMS and the state. The Guide explains how to streamline enrollment through the use of a single enrollment form to be used for both Medicaid and Medicare enrollment. The Guide also discusses other issues related to enrollment, including the role of the State as an authorized representative for an individual, the timing of enrollments and their effective dates, loss of Medicaid eligibility, and enrollment in a "stand-alone" Medicare prescription drug plan (PDP) as it relates to Medicare Advantage enrollment.

Enrollment Questions & Answers

1. *Will SNPs offering integrated dual eligible programs be able to use a single enrollment form?*

   CMS will allow the use of a single enrollment form to enroll into a combined Medicare Advantage/Medicaid product as long as it meets all of the Medicare requirements. CMS has permitted the use of a single enrollment form in the past. Examples of States that have used such a form include Massachusetts, Minnesota, and Wisconsin.

2. *What are the Medicare requirements for a single enrollment form?*

   A model enrollment form that meets all of the Medicare requirements and includes additional information that the plan may want to capture is attached (Attachment A). A list of the data elements included in this form is also attached (Attachment B). Attachment B distinguishes between those elements that are required to complete the Medicare enrollment from those elements that are provided for plan informational purposes. Please note that the most recent model enrollment form from Chapter 2 of the Medicare Managed Care Manual should be used when developing an integrated care enrollment form as these forms are periodically updated to meet current requirements. The Medicare Managed Care Manual can be found at http://www.cms.hhs.gov/HealthPlansGenInfo/downloads/mc86c02.pdf .

3. *What are the Medicaid requirements for a single enrollment form?*

   Each State has the discretion to add any information that they would require to the Medicare enrollment form. Some examples of information that the State may want to capture in this form include:
   - Medicaid number;
   - required authorizations and releases;
   - other health insurance coverage;

- beneficiary rights and responsibilities; and
- plan responsibilities.

4. *Can the order or content of information in the model enrollment form provided (Attachment A) be changed?*

   Yes, as long as the required information specified in Attachment B is maintained in the document. States may customize an enrollment form to include all applicable information for their State. All enrollment forms will be reviewed and approved by CMS to ensure all required elements are included. The State also has the discretion to have the enrollment form meet State literacy requirements that are more stringent than the Federal requirements.

5. *What is the process to get approval of an integrated enrollment form?*

   The enrollment form is considered part of marketing materials and should follow the same approval process. In many cases, CMS regional offices and the States have worked together to create a streamlined process for review of marketing material on a "one-stop shopping" basis. The procedures are agreed to by CMS, the States, and health plans so that all parties understand the process and can work together to facilitate an efficient process. There are a number of approaches that can be used. Please refer to the "Marketing How To Guide" for examples of marketing material approval processes. Upon approval, the enrollment form may be used for enrollment into that particular integrated program.

6. *Does Federal law permit States to act as authorized representatives to enroll Medicaid beneficiaries in SNPs?*

   Medicare defers to State law regarding authorized representatives. Therefore, if a State law permits the Medicaid agency (or the State) to act as a legal representative for this purpose, Medicare would recognize the State's authority. The beneficiary would need to be given advance notice of any authorized representative in order that the beneficiary could change the election.

7. *Do coordination issues arise as a result of the manner in which enrollments are processed and submitted under the Medicaid MCO program or the Medicare Advantage program? What roles can the State or brokers play in the enrollment process?*

   Yes, coordination issues may arise between Medicare and Medicaid due to different enrollment rules and processing requirements. Brokers and States could provide enrollment services to a MA plan in a type of subcontractor arrangement. However, enrollment brokers and States that utilize enrollment brokers for their Medicaid managed care programs need to be careful not to enter into such subcontracting arrangements if they would violate CMS' Medicaid requirements that enrollment brokers be free from a conflict of interest and be independent.

8. Do the effective dates of enrollment need to be the same for Medicare and Medicaid?

Medicaid and Medicare enrollment effective dates do not need to be the same in order to use a combined enrollment form. The effective date for Medicare Advantage enrollment must always be on the first of a month. A Medicare enrollment made during a Special Election Period (SEP) or Open Enrollment Period (OEP) is generally effective the first day of the month following the receipt of a completed enrollment election.

If the State is unable to enroll an individual within the same timeframe, an individual may receive Medicare managed care and Medicaid fee-for service until he/she is enrolled under Medicaid managed care. If a State allows a Medicaid managed care plan enrollment effective date to be any day of the month, the individual may enroll in the Medicaid managed care plan and receive Medicare fee-for service until he/she is enrolled in the Medicare Advantage plan on the first of the month.

9. Can integrated programs have a continuous open enrollment period?

Dual eligibles have a Special Election Period (SEP) to elect a Medicare Advantage plan as long as they remain dually eligible, therefore duals can enroll into and disenroll from Medicare Advantage plans at any time. A dual eligible may also change Part D coverage when he/she changes Medicare Advantage plans or enrolls in Medicare Advantage plan for the first time.

Dual eligibles have an SEP lasting from the time the individual becomes dually-eligible and exists as long as they receive Medicaid benefits. In addition, Medicare Advantage eligible individuals who are no longer eligible for Title XIX benefits have a 3-month period after the date it is determined they are no longer eligible to make an election.

It is the State's option to allow open enrollment or require a lock-in period for the Medicaid managed care enrollment.

10. What happens when an individual who is enrolled in a Special Needs Plan loses Medicaid eligibility?

A SNP that exclusively enrolls special needs individuals may continue to provide care for up to six months for a member who no longer has special needs status as long as the plan can provide appropriate care. For example, a dual eligible individual who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if that individual would likely regain eligibility within six months. If the member does not re-qualify within this time

period, s/he must be involuntarily disenrolled with proper notice, from the plan at the end of this period. The SNP may choose any length of time from 30 days through 6 months for deeming continued eligibility as long as it applies the criteria consistently among all members and fully informs members of its policy.

The plan must provide the beneficiary with a minimum of 30 days notice after the plan determines the member is no longer eligible. This notice must provide the member an opportunity to prove that s/he is still eligible to be in the plan. Upon involuntary disenrollment, CMS will grant the beneficiary a Special Election Period (SEP) in order that s/he may enroll in another MA plan or obtain coverage to supplement Original Medicare.

In the case of a retroactive Medicaid disenrollment, an MA SNP may not retroactively disenroll the beneficiary. The plan may disenroll the member only after providing a minimum of 30 days' notice.

A disproportionate percentage SNP may not involuntarily disenroll a member based on loss of special needs status. However, the SNP must provide the beneficiary with a minimum of 30 days notice of any changes in costs and benefits resulting from the change in status and provide an opportunity to prove that s/he still meets special needs status.

11. What happens if a dual eligible who is enrolled in an integrated plan enrolls in a Prescription Drug Plan (PDP) for Part D coverage?

A beneficiary in a Medicare Advantage plan who enrolls in a Medicare Prescription Drug Plan (PDP) will be automatically disenrolled from the Medicare Advantage plan to the Fee-for-Service Medicare plan.